PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE 12/30/1899

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS# _____ BIRTHDATE 12/30/1899

CHECK APPROPRIATE BOX ☐MINOR ☐SINGLE ☐MARRIED ☐OTHER

IF COLLEGE STUDENT ☐FT ☐PT NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE/PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU _____

EMERGENCY CONTACT _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____

ADDRESS _____ HOME PHONE _____

DRIVER LIC # _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE ☐YES ☐NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO _____ TEL # _____ GRP # _____ POLICY/ID # _____

INS CO ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE _____ MAX ANNUAL BENEFIT _____ HOW MUCH HAVE YOU USED _____

DO YOU HAVE ADDITIONAL INSURANCE ☐YES ☐NO IF YES PLEASE COMPLETE THE FOLLOWING SECTION:

NAME OF INSURED _____ RELATIONSHIP _____

BIRTHDATE _____ SS# _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO _____ TEL # _____ GRP # _____ POLICY/ID # _____

INS CO ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE _____ MAX ANNUAL BENEFIT _____ HOW MUCH HAVE YOU USED _____

_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

REGISTRATION